

# POSITIVE SOCIAL SUPPORT NEWSDIGEST

A "BEING ALIVE" PROGRAM

VOLUME 4 NUMBER 1

SACRAMENTO, CALIFORNIA

January/April 1991

For people who are  
HIV positive  
and for those  
who are supportive

## Update on ddl and ddC Citizens' Petition

By Arturo Jackson III

The Food and Drug Administration (FDA) is reviewing the citizens' petition submitted to the agency in December 1990, urging the approval of the AIDS drugs ddl and ddC by March 1st.

According to FDA press spokesman, Brad Stone, "We are reviewing the citizens' petition and our decision will go beyond these two drugs and impact the entire drug approval process. The FDA normally has 180 days to respond to citizens' petitions and it is unlikely we will render a decision by the deadline."

The petition signed by more than 180 San Francisco area doctors, nurses and medical aides, requested early approval to the drugs based on preliminary trial results indicating ddl and ddC are both effective in slowing virus reproduction. The medical workers emphasized that access to ddl and ddC is important for healthier people with HIV who cannot tolerate AZT and would not qualify for the new drugs under compassionate use protocols of experimental drugs. Approximately 5 in every 100 people with HIV "fall through this crack in medical care," Dr. William

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## Apply Now For "MR. MIB" Insurance

by Marghe Richards

Major risk medical insurance, implementation of Assembly Bill 60 which was passed in 1989, went into effect in January. The measure involves setting up health insurance coverages for high risk people, people who have been turned down by other insurance companies, and those who are unable to buy health insurance coverage elsewhere.

An estimated 5.2 million Californians have no health insurance. A quarter million of them are barred from policies because they have severe

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## Take A Second Look, It's Worth The Effort

By Sheila R. Enders

"Four to five years ago I was cynical and thought the chance to arrest progression of HIV was very poor, but with AZT and other newer drugs, it is now at least theoretically possible to stop viral replication in humans", recalls Dr. Bary Siegel, an internist in private practice in Sacramento. Dr. Siegel's comments followed the appearance of an article, "HIV Alone May Not Be The Cause of AIDS", in the January 13, 1991 Forum section of *The Sacramento Bee*. Having treated many patients with HIV/AIDS for a number of years, both at U.C. Davis Medical Center and in private practice, Dr. Siegel feels this article de-

serves further scrutiny.

"Tremendous progress has been made in the last five years. In the early days the outlook was dismal," says Dr. Siegel. "The time from diagnosis of the first opportunistic infection was a rapid downward spiral to death in as little as seven months. Now, however, large numbers of people who reach CDC criteria for the definition of AIDS remain clinically well one to three years out."

Dr. Siegel feels the article is somewhat misleading and is concerned that some people with HIV/AIDS may delay seeking treatment or not follow-

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## The Danger (and Irony) of the CDC Debate Over Health Care Workers

by Keith Clark

Since the early 1980s when AIDS began being clinically observed, the nation's health-care workers have been the front-line troops in the unremitting fight against the epidemic that has killed over 100,000 Americans. Some of those infected with HIV - and the numbers continue to grow - have been the very doctors, dentists, nurses and other medical workers involved in the battle.

Many - perhaps most - of these health-care workers with HIV

infection have continued to work for years without a single documented case of transmission of the virus to the patients they've treated.

But in July of last year, the Atlanta-based Centers for Disease Control disclosed that a Florida woman, Kimberly Bergalis, had apparently become infected with HIV by her dentist who subsequently died of AIDS. The single documented case was followed by two additional patients of the same dentist who have been diagnosed as HIV-positive with no other apparent risk

factors known.

The CDC reports sparked a tense debate in medical circles over whether patients should be protected from possible exposure to HIV from their health-care workers that culminated in two days of hearings at the agency in late February.

Since the reported patient infections, both the American Medical Association and the American Dental Association have recommended that their members who are infected with

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- Submitted materials may be edited for length and clarity.
- PSSN reserves the right to refuse sexually explicit ads. Ads will run for three consecutive issues, unless cancellation is requested prior to publication of third issue. All ads must be resubmitted after each three-issue run.
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## From the Co-Editors...

There are several new items of note with this issue of *PSSN*. First, *PSSN* is now under the guidance of Co-Editors, Sheila Enders and Judy Ludwick. Sheila has been involved in research and clinical drug trials with HIV/AIDS patients and AIDS Education/Prevention programs for more than three years. Judy has an extensive background in journalism and health promotion. She has published and edited newsletters, been a feature writer for newspapers and has written and had accepted numerous grant proposals. Both have a commitment to bring HIV-positive individuals, their families and friends up-to-date information and features relevant to the topic of HIV.

Second, our area of distribution has been expanded to include Yolo, San Joaquin, Placer, El Dorado, Nevada, and Yuba counties.

Third, a new feature, "Personal Perspectives" invites readers to contribute a personal story about any part of their journey with HIV.

We would especially like to offer our thanks and appreciation to Arturo Jackson III who is helping make the transition from his leadership to ours much easier. Art will continue to serve on the Editorial Board where his experience will help assure a continued favorable response and acceptance of *PSSN*.

We also wish to thank Stephen Crow and Joe Chase for all of their hard work on *PSSN*. We hope they will continue to provide *PSSN* with their knowledge and viewpoints. And, we wish to thank all of those people who have been involved with *PSSN* and have made this newsdigest such a success. We plan to maintain *PSSN*'s current focus and continue to develop new features, with your assistance.

Beginning with the next issue (May-June 1991), advertising space will be available. If you are interested in obtaining advertising space, please call *PSSN* at the Lambda Center (916) 442-0185. We encourage anyone who is interested in contributing information for the "Resource Guide," articles or

article ideas to contact *PSSN* through the phone number listed above.

*PSSN* is funded by a grant from the Sacramento County Health Department. It is published six times a year and will be available in May-June, July-August, September-October, and November-December. Deadlines for each issue will be the 12th of the month prior to publication. (April 12th, June 12th, August 12th and October 12).

This issue contains a reader's survey. Please be sure to complete the survey and mail to *PSSN*, P. O. Box 163654, Sacramento, CA 95816 by April 12th 1991 so we can make the publication as responsive as possible to your needs and to meet the funding requirements of the Health Department.

Thank you for your support of the Newsdigest. We look forward to our continuing combined efforts.

—Sheila Enders & Judy Ludwick

### PSSN Staffing Opportunities

- Writers
  - AIDS Knowledge
- Person(s) to assist with computer layout
- Person(s) to assist in
  - Compilation of the "Resource Guide"
  - Distribution at restaurants, bookstores, bars
  - Envelope stuffing for copies to be mailed

To Find Out How You Can Help Please Call PSSN at 916/442-0185

### Deadline for the May/June PSSN is April 12, 1991

Send copy to

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PO Box 163654  
Sacramento, CA 95816



## Pool Party Alert!

HIV positive people and their friends are reminded to be on the alert for news in *PSSN* about the monthly pool parties starting this Spring. For Information Call Mike Kelly at 916/878-2793.

## Nutrition Often Neglected In HIV Treatment

By neglecting the role nutrition may play in the course of HIV infection, health care providers are missing an opportunity to improve the quality of patients' lives and possibly even prevent protein calorie malnutrition (PCM), a condition that commonly occurs in the late stages of HIV disease.

"Physicians have very little training in medical nutrition, so in terms of a treatment plan that integrates appropriate nutritional support during the course of the disease, there are probably very few physicians who really are doing this on a comprehensive basis," according to Gordon Nary, executive director of the Physicians Association for AIDS Care (PAAC) in Chicago.

There is growing evidence to support the hypothesis that PCM could be prevented in 20% to 30% of patients who acquire the condition, if they received nutritional support as part of early intervention, Nary says. He compared the role of nutrition in HIV disease to that of other prophylactic therapies.

Some nutrition specialists believe that severe malnutrition adversely affects immune function and increases the vulnerability of the patient to the environment. It may also increase the morbidity of AIDS and may shorten the already limited life expectancy of people with the disease.

"Malnutrition is one of the most frequent causes of death among people with AIDS," says Kristin Weaver, RN, MS, CNSN, a nutrition support nurse at San Francisco General Hospital and assistant clinical professor of physiological nursing at the University of California in San Francisco.

Optimal nutrition will prohibit progressive weight loss, reduce the frequency of secondary in-

fections, enhance patients' response to medical therapies, and improve strength, Weaver says. If people are well-nourished, they'll have a better sense of well-being and a better quality of life.

Ideally, physicians should be working with nutritionists to monitor the status of HIV-infected patients, Weaver says. Nutritional assessments should be conducted as soon as a patient is found to be infected with HIV.

Donald Abrams, MD, assistant director of AIDS Activities at San Francisco General, says that physicians probably don't pay as much attention to patients' nutritional status as they should, primarily because nutrition has not been a major focus in medical schools.

"In our clinic, we do engage the services of our nutritionist, and if we think that a person might benefit from a referral, we refer them," Abrams says. "But I think (nutrition) is something that does need to be integrated into medical education earlier, so that we are in tune to think about it when we deal with our patients on a daily basis."

Because physicians are not monitoring nutritional status, some patients seek nutritional advice from sources outside of the medical community, Weaver says. Some alternative nutritional interventions, such as fad diets, may be harmful to their health.

Weaver is a member of the Task Force on Nutritional Support in AIDS, which consists of academic, government, and hospital specialists in nutrition or treatment of HIV infection. The task force recommends that physicians discourage non-traditional dietary practices, such as macrobiotic diets, herbal powders, and vitamin megadosing, because those diets do not ensure adequate

and balanced intake of nutrients and can compromise immune status.

The task force also advises physicians to conduct a routine blood count with differential, a complete work-up for anemia, and an investigation for specific micronutrient deficiencies, such as zinc and selenium. Based on those findings, nutritional counseling should be provided, including the options available to supplement a regular diet.

Too often when physicians have attempted to address nutrition in HIV-infected patients, they recommended high-calorie, high fat foods, according to C. Wayne Callaway, MD, associate clinical professor of medicine at George Washington University, Washington, D.C., a specialist in diet, nutrition, and eating disorders.

Adding foods high in fat to a patient's diet may actually exacerbate the problem, he says.

"A lot of people with AIDS have diarrhea, and what you have to do is find out if you can find out what the cause is," Callaway tells *AIDS Alert*. "There's evidence that HIV will affect the lining of the bowel and lead to malabsorption. If you take someone who is not absorbing fat and give them high-fat foods, they get more diarrhea."

For patients with diarrhea, physicians should advise them to reduce their fat intake and increase the amount of complex carbohydrates in their diet, Callaway says. Many people begin to feel better, and the diarrhea becomes less frequent.

Certain drugs commonly prescribed to reduce diarrhea may cause problems for HIV-infected patients, Callaway warns. For instance, Lomotil and Imodium, which paralyze the bowel, may be fine for short-term treatment, but if they are used

for a long period of time, they can cause an overgrowth of bacteria.

Physicians need to investigate the cause of malnutrition in HIV-infected patients, Callaway says. For example, patients may not eat because they are depressed. If that's the case, the depression needs to be treated. Thrush or other conditions could be making it difficult for patients to eat. If so, those conditions should be treated.

"You really need to go through each of the mechanisms to see which ones are causing the problem and intervene as close to the pathology as you can, rather than just covering it over by giving Lomotil and Imodium, and saying, 'Eat more fat,'" Callaway says.

One problem physicians have faced when they have tried to provide nutritional support to patients is that third-party payers rarely reimburse for nutritional intervention. Even with tube feeding, third-party payers are sometimes reluctant to pay for the nutrients, although they usually pay for the tubes and pumps, according to Mike Tootell, of Ross Laboratories in Columbus, OH, a nutritional supplements manufacturer. In addition, most insurance companies rarely pay for oral supplements. However, some state Medicaid agencies will pay for oral supplements as long as physicians document that nutritional support is needed, he says.

Nary compared the insurance industry's attitude toward nutritional support to its initial response to aerosolized pentamidine. The treatment was shown to be effective long before insurance companies agreed to pay for it.

However, once insurance companies recognized that it

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# Treatment News...

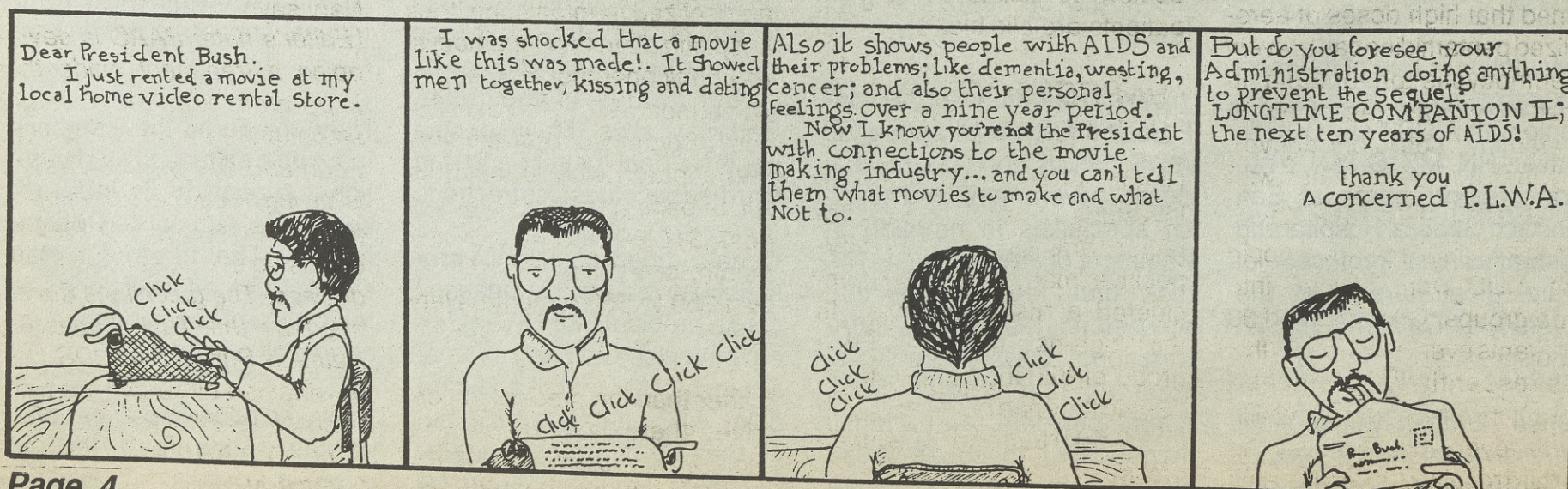
## Nutrition Related Problems and Dietary Intervention Strategies

The ultimate goal of nutritional intervention is to provide an optimal diet composed of nourishing food which is consumed orally if possible.

The first choice of feeding a PWA is food orally. A balanced diet consisting of a variety of nourishing food is suggested to provide optimum nutrition. When complications develop and interfere with oral ingestion of food, dietary modification is necessary. This chart presents an overview of some of the common symptoms which prevent the intake of a diet of usual foods and some intervention strategies to relieve the problems.

	Symptoms	Dietary Intervention	Practical Food Tips
Oral Lesions	Difficulty chewing & swallowing	<ul style="list-style-type: none"> <li>Mechanically modified diet-bland, soft, semi-liquid foods</li> <li>High Calorie/high protein supplements</li> <li>Mild flavored foods at room or cold temperature</li> <li>Avoid acidic or tart foods</li> </ul>	<ul style="list-style-type: none"> <li>Mashed, pureed or blended fruits &amp; vegetables</li> <li>Prepare baked &amp; steamed foods like fish, ground beef, custard, pudding</li> <li>Canned fruits (skin &amp; seeds removed)</li> <li>Use a straw for drinking vitamin C-fortified apple or grape juice</li> </ul>
Esophageal Lesions	Feeling of obstruction in chest & difficulty swallowing	<ul style="list-style-type: none"> <li>Mechanically modified diet (see above)</li> </ul>	<ul style="list-style-type: none"> <li>Drink liquids like milk shakes (milk &amp; ice cream), egg cream (chocolate syrup &amp; carbonated water), diluted or undiluted fruit nectars (apricot, pear, peach)</li> </ul>
GI Infections	Nausea & vomiting	<ul style="list-style-type: none"> <li>Carbohydrate foods in morning</li> <li>Small frequent meals and snacks</li> <li>Frequent intake of fluids, slowly between meals</li> <li>Avoid fried foods</li> </ul>	<ul style="list-style-type: none"> <li>Dry toast or crackers first thing in morning</li> <li>Chew food slowly and eat small portions of food frequently</li> <li>Drink fruit juices and eat smooth soups (creamed, pureed)</li> <li>Bake, broil, boil &amp; steam foods</li> <li>Open windows while cooking</li> </ul>
	Diarrhea	<ul style="list-style-type: none"> <li>Frequent fluids and electrolyte supplements (including high potassium juices)</li> <li>Low fiber, low lactose foods</li> <li>Small frequent feedings</li> <li>If persistent and severe diarrhea, enteral nutrition formulas or parenteral nutrition only, under the direction of a physician</li> </ul>	<ul style="list-style-type: none"> <li>Fruit ices, fruited gelatin &amp; high potassium juices (cranberry, orange if tolerated)</li> <li>Diluted or undiluted fruit nectars (apricot, pear, peach)</li> <li>Pureed banana &amp; canned peaches</li> </ul>
	Loss of appetite, anorexia	<ul style="list-style-type: none"> <li>Small frequent feedings</li> <li>Calorically dense foods</li> <li>Drink fluids after meals</li> <li>Rearrange time of large meals/snacks to coincide with time appetite is best</li> <li>Calorically dense enteral formulas to supplement diet as directed by a physician</li> <li>If significant weight loss, tube feeding may be indicated as directed by a physician</li> </ul>	<ul style="list-style-type: none"> <li>Eat a number of small meals and snacks throughout the day</li> <li>Add nonfat dry milk to potatoes, casseroles, soups</li> <li>If appetite is good in morning, eat a large morning meal</li> <li>Food should be served attractively</li> </ul>

### Nutritional News & Views



# Treatment News...

By Sonya Cox

## GOOD NEWS: NEW PCP TREATMENT

Oral trimethoprim/dapsone is proving to be as effective in treating episodes of PCP pneumonia as the standard treatment, trimethoprim/sulfamethoxazole (Septra/Bactrim), but with fewer side effects, say researchers at UC San Francisco. Good news also for those 10 percent or so who become resistant to aerosolized pentamidine after 14 months or so and develop PCP.

Some physicians feel this 10 percent default statistic needs to be more openly discussed: the pneumonia may come as a complete surprise to a person taking pentamidine, not only causing fear and frustration, but also perhaps the possibility that the person will not seek immediate treatment for pneumonia symptoms, thinking it must be something else. Additionally, some physicians who aren't extremely familiar with AIDS may not quickly recognize the pneumonia for what it is if they think it can't happen to a person on pentamidine. Pneumocystis pneumonia symptoms are not the same as would be associated with a bad cold. Watch for shortness of breath, dry hacking cough, fever, chest discomfort, running out of breath trying to climb stairs.

## IT'S OFFICIAL NOW

Completed studies have confirmed that high doses of aerosolized pentamidine can prevent pneumocystis pneumonia in most individuals (as many as 90 percent; see story above), and that its use together with AZT is even more effective.

For the tests, over 400 people with AIDS were divided into three groups. One received 30 milligrams every two weeks (this was essentially a placebo group); one received 150 milligrams every two weeks; and the third received 300 milligrams

every four weeks. After 18 months, only eight people in the 300 milligram group had had a recurrence, while 22 people in the 30 milligram group had. (Results were termed "intermediate" for the 150 milligram group.) The trend here is that a higher dose every four weeks is better than a lower one every two weeks.

## NEW CMV DRUG AVAILABILITY

The Swedish drug company that makes the drug foscarnet says it will provide the drug at no charge, on a case-by-case basis, to HIV-infected people with cytomegalovirus infections who can't be helped by ganciclovir, or who can't take ganciclovir because they're on AZT. This will help alleviate the huge and horrible problem faced by PWAs over past years of having to choose between being able to see and being able to stay healthy, since AZT and ganciclovir don't mix.

CMV is a herpes virus that ordinarily lies dormant in about 90 percent of all gay men, both healthy and those with HIV. It can affect major organs and most commonly results in retinitis (infecting the retina of the eye), encephalitis (infecting the brain), pneumonia (in the lungs), or colitis (in the bowels). Foscarnet can't cure CMV but slows its progress markedly.

Thank you, Astra Pharmaceuticals. The company has established a toll-free number for doctors to call to see if their patients are eligible.

## UNPROTECTED ORAL SEX PROVES UNSAFE

Results of a recent UC Berkeley study have placed unprotected oral sex with an HIV-positive man, previously considered a "risky" behavior, in the high-risk category. Of a group of 82 HIV-positive men, 20 said they had never engaged in any risky behavior other than oral sex.

Just over a year ago, the San Francisco Health Department reported the first documented cases in which men became infected with HIV through oral sex. Four years before that, the Surgeon General warned that oral sex might be a pathway for HIV, but his warning was met with much debate by other health authorities and many in the gay community. Due to the unfortunate unacceptance of this theory and the long incubation period in most cases of the virus, we will undoubtedly be seeing many hundreds or thousands of men become symptomatic over the coming years from HIV transmitted in this manner.

Other findings of the study showed that the infection risk was higher with the use of a douche or enema before anal intercourse, that the risk was unmistakably higher for those with two to four partners than for those with one partner, and approximately 30 percent of those who used condoms during the year of the study had experienced condom breakage on at least one occasion. Condom breakage is generally attributed to improper use, improper storage, or poor manufacture. Additionally, anal intercourse creates much more friction than condoms were originally designed to withstand, so the breakage rate is higher in anal intercourse than in vaginal intercourse.

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was more economical to pay for aerosolized pentamidine than hospitalization for *Pneumocystis carinii* pneumonia, they became more willing to cover the cost of prophylactic treatment. While parenteral feeding for AIDS patients with PCM can cost \$10,000 to \$15,000 a month, oral supplements may cost \$50 to \$60 a month, Nary says.

"Other than the medical imperative, there is certainly the economic imperative, and that's something that the third-party

Take extra care to use good latex condoms (never sheepskin), and lots of lubricant (with non-oxynol 9 as a backup safety measure. This ingredient has been shown to destroy HIV virus under some circumstances.) The study findings dispute the previous belief that the acidic content of saliva and stomach juices may be strong enough to kill the HIV virus. The virus can enter through any scratch or cut it comes into contact with, and has the ability to stay alive—perhaps much longer than previously thought in moist environments. The mouth is often scratched from toothbrushes, gum disorders, potato chips, or numerous other reasons. And granted, stomach acids are strong, but there is almost no way to get semen directly into the stomach without scratching the back of the mouth or throat, no matter how talented you are.

## PLEASE USE CONDOMS

The correct and constant use of condoms and spermicides can greatly reduce the likelihood of HIV transmission. But a Centers for Disease Control study shows that knowing this fact has no impact on getting people to use them, especially when alcohol or other stimulants are involved.

The study found that men who had not used alcohol or other

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payers need to be looking at," Nary says.

(Editor's note: PAAC is developing a treatment guide that integrates nutrition at every stage of the disease. The U.S. Food and Drug Administration is having a document developed that will review current research on the role of nutrition in HIV disease. The guidelines developed by the Task Force for Nutrition Support in AIDS can be obtained by writing the task force at 19 W. 21st. St., New York, NY 10010.)

—AIDS Alert

# Personal Perspective

## Climbing Up The Ladder

By Richard Locke

Some months ago I heard Dr. Flynn speak at a Healthy Living Workshop at the Sacramento AIDS Foundation. He explained that the average person begins his T4 downward slide from 1000 or 1200 T4 cell count. He said that a person will lose about 100 T4 cells a year. This is why the average person has about 8 to 10 years of health without coming down with an opportunistic disease that determines a case of ARC or AIDS. Usually this loss of T-cells is within this time span of up to 12 years and even more. Depending on other factors the time span can be much less.

Later, in a Project Inform (PI) Newsletter it was stated that anti-viral therapy should begin as soon as possible on this downward slide to prevent that occasion, around 200 T-cell count, when the opportunistic diseases begin to show. In other words, beginning AZT therapy at around 500 T-cells is better than beginning at 200 T-cells. The several reasons given by PI are very good. One is that the toxicity of the AZT is better tolerated at 50 than it is at 200, generally speaking that is. The other reason and a very important reason is that the downward slide is abruptly halted and levels out at about 500. Without AZT intervention the slide is uninterrupted.

Most studies of AZT, ddC, ddI, other anti-virals, etc., are only begun when the T-cell count goes below 200. PI and medical authorities state that once down the slide there is no way to go back up. Many times there are gains of maybe 100 or so T-cells back up to a total of 300 T-cells. Any higher is very rare. This is why most people now are recommending therapy as soon as possible. This is why the HIV antibody test is so important. Life extension is definitely here with the new anti-virals. Get tested now!

The T-cell testing is a general indication of what is going on but is not definitive to a great degree of accuracy about anything. In the description above, it is better to be safe than sorry.

My climb back up the ladder of T-cell counts began in June of 1988 with a count of 389. There was a tremendous drop downward to 120 T4 cells in December of 1989. In August of that year, I became despondent. All of my chosen family except three or four people had died. Those who were left were also infected and sick. I stopped my Dinitrochlorobenzene (DNCB) therapy. The downward trend I feel was because I stopped my therapy and the stress induced by the despondency. In January 1990 I had a dramatic rise because I started my therapy again because I had hopped out of this despondent period. In February 1990 I had a relapse of the despondency and stopped my therapy again and dropped my T4 cell count to 107. I bounced back again and began my DNCB therapy along with entering a ddC Study and by April 1990 I was up to 459 T4 cells. I have continued the therapy and climbed back up the ladder.

My health is in very good condition. I have been involved in several experimental therapies

that are so wonderful that instead of being dead as predicted by all the statistics, I have been given about five years more of living, according to the statistics concerning my T4 cell counts. I have climbed the ladder from 107 T-cells last January to 485 this January. I have become a medical oddity by all the medical accounts I have been reading. These accounts say that once you go down the ladder there is no climbing up the ladder. I am very happy to prove these accounts wrong.

One therapy, DNCB, that I have been doing for about six years, is called an immune modulator. This, I believe, is the reason I have climbed the ladder. My immune system is replacing and increasing the amount of T-cells. The happy news is that for the first time in six years the medical community is listening to reports like mine and have started a study in San Francisco at Children's Hospital. I have waited a long time for the results of myself and others to stimulate and begin this study and make it open to others. Great news!

The other therapy that has been tremendous in its results, besides my innate ability to struggle and to fight this disease with all the resources at hand, is the study I'm involved in at UC Davis Medical Center with a chemical

called ddC. ddC is an anti-viral. The anti-viral protects my new T-cells from being infected with the HIV virus.

The new study I will become involved in in the next several weeks is combination therapy. This therapy is the combination of the drugs AZT and ddC. According to the statisticians, after 18 months of either therapy the virus will become resistant, in about 30 percent of the cases, to AZT, or ddC alone. When combined, the two anti-virals knock out the resistant viruses leaving many more months of active anti-viral activity. The results may be "THE CURE" we have been looking for in the best case scenario. The worst case scenario is that health can be retained for a longer time which could be the time necessary for the real cure to be found.

It well could be that the DNCB, AZT, ddC scenario is the one that will work. Hope is running high and in the meantime my health is good and improving with these therapies. I am climbing the ladder of health...

For information about the DNCB Guerrilla Clinic contact Richard at 372-4170.

*(This article is the personal perspective of the author. If you have questions about or are interested in the topics mentioned, you should discuss them with your physician.)*

## SAF Offers New Assistance

By Arturo Jackson III

Two new volunteer programs offering assistance to individuals diagnosed with ARC (AIDS-related complex) and AIDS (acquired immunodeficiency syndrome) are being implemented by the Sacramento AIDS Foundation.

The Benefits Volunteered Program and Mental Health Professional Network will restore a few of the services provided by SAF until late last year when the organization faced severe

funding cutbacks. According to Shoshana Zatz, SAF Client Program Developer, "Since our budget cuts and loss of staff, we no longer have the resources available to offer clients mental health counseling or even to help clients fill out forms as they apply for benefits."

The Benefits Volunteer program will have trained volunteers available to assist SAF clients with completing detailed government forms required when a person applies for benefits from a multitude of agencies as a

disabled person. The first group of Benefits Volunteers numbered 16, and were trained in the application requirements for government programs ranging from food stamps to Social Security.

The Mental Health Professional Network will link SAF clients in need of mental health therapy with psychiatrists, psychologists and social workers. The mental health professionals participating in the program have low cost fees or accept

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# Personal Perspective

## Make Your Move This Spring

By Sonya Cox

We'd like to call for all PSSN readers to surrender! Please *give up* your struggle to hide from the fact that AIDS is here among all of us. Stop putting off not knowing your HIV status. Understand that HIV is not a death sentence; but you can't retaliate against an enemy that you refuse to acknowledge. Knowing your position is only the first step in this war, and the longer this first step is put off, the further behind you will be when you need all the knowledge you can absorb for the individual battles.

None of it is easy: sorting your way through your own personal interpretation of how and why you became positive, or dealing with those nagging guilt feelings because you discover that you are still negative, and laying a strong foundation for a safer future is as difficult as choosing which religion you wish to convert to.

We are all going to leave this earth some day, and testing

positive may give some people the advantage of making wise choices sooner than the rest of us, of cherishing moments that constantly come our way. Learn early how to stay healthy and take care of a fragile immune system. Learn the roles that stress and depression play, and how to keep them away so you can stay healthy. The complexity of it all demands and allows a wide variety of interpretations. Feeling anxious, afraid and overwhelmed with knowledge that you wish you'd never heard about means, in fact, that you're dealing with the issue realistically. Nothing in your life will ever be more complicated, confusing and time-consuming.

The stress of living with the possibility that you're carrying the virus can be unbearable, but knowing and accepting your status will give you power. The anger—about the fact that you may be diagnosed as positive, or about the snail's pace at which medical research has moved—eventually evolves into a potent enthusiasm about life that will

bring you joy over things that were once too trivial to notice. Testing positive will afford you an awareness of the preciousness of your time on earth, and an opportunity to better choose how to spend it. And it will also scare the wits out of you until you've armed yourself with the knowledge of how to deal with it emotionally, medically, and spiritually.

Don't try to do this thing alone: there's a huge support system waiting for you out there, and you will meet some of the most fascinating and wonderful people on this earth, and they will help you find love and peace. This year take that step to get tested, so you can move along with your life with hope and knowledge. Get busy now to get well or stay well. There's only one way to win this battle: by focusing on the right target.

Never forget the 98,532 we've lost in this war. But focus on the hope and the possibility of a cure. Focus on what you can do to make this happen: write to your congressmen, become a volunteer, donate to or help organize fundraising, and of

course, learn how to make sure the virus isn't passed to you if you don't have it, and how not to pass it on if you do. Many studies indicate that people may be most infectious before they have any symptoms or know that they have HIV in their body. Some may test negative for up to two years and be carriers.

Don't fall for ads that say "HIV-negative looking for same." They may not be, and you may not be. Have safe sex EVERY time with EVERY person; protect yourself each time as if everyone you meet is positive. Resolve to find out before summer whether you're positive or negative with the virus (tests are more than 95% accurate), and resolve to do something this year (for someone else, or at least for yourself) to make a difference in this epidemic.

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*Condoms...continued from Page 5*

drugs before sex were 3.6 times more likely to use a condom. It's long been known that drinking and drugs impair decision-making capabilities, but the findings of this study are frightening in time like these.

You can help get this epidemic under control—and keep your health, whether you are currently HIV-positive or negative—if you use condoms every time you engage in high-risk activities. Learn what these categories are, learn how to properly use condoms to avoid breakage, and learn how to have hot sex with condoms. Call the Sacramento AIDS Foundation (448-2437) and take their 'safe sex can be fun' workshop, "The Buddy Connection."

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*SAF...continued from Page 6*

Medi-Cal insurance coverage as payment.

For more information regarding the Benefits Volunteers Program or the Mental Health Professional Network, contact Shoshana Zatz at The Sacramento AIDS Foundation, 916/448-2437.

**Page 7**

## NIH Will Try A New Approach to AIDS Trials

Under pressure from Congress to test more AIDS drugs, NIH is gearing up a new clinical trials program including quick trials of "unproven therapies" that attract high public interest even though their scientific promise is low. Officials don't quite call the new program a debunking exercise. But they make clear that debunking will be a part of it.

Daniel Hoth, director of the AIDS Division in the National Institute of Allergy and Infectious Diseases (NIAID), describes the new effort as "a third leg to our clinical trials now through the 47-center AIDS Clinical Trial Group (ACTG), which currently has about 90 studies under way, and the Community Programs for Clinical Research, launched

last year, which has 18 centers in operation. In addition, five NIH-funded vaccine evaluation centers are involved in three on-going trials, and intramural researchers conduct some trials.

Under both the ACTG and community trials programs, the researchers choose the drugs to be investigated. In the new program, NIAID will create a contract mechanism for trials of drugs it selects. Hoth envisions small Phase I or Phase II trials of therapies that the other groups either can't or don't want to investigate—"particularly agents that are in very widespread use out there, where the public really has a need to know, 'Does it work or does it not?', but the scientific justification is perhaps not as

great as it ought to be."

By this fall, NIAID aims to select at least one prime contractor to conduct the trials or to organize them through subcontractors. Once such a mechanism is in place, NIAID will be able to start a trial within a matter of weeks.

Hoth, an oncologist who monitored the National Cancer Institute's trial of laetrile in the early 1980s, says the targets would be "unproven therapies that are in common use. Our threshold would be something that achieves the level of widespread use where data, even negative data, would be useful in helping people make the right decision."

—The Journal of NIH Research

# R E S O U R C E

## Support Groups

### Antibody Positive Support Group

Membership: People who are HIV-positive, have ARC or AIDS, male and female, straight and gay.

Contact: Donna Robertson (916) 448-2437

Fee: None

Time: 1st and 3rd Wednesday, 7:30 - 9 p.m.

Place: Sierra II, 2791 24th Street

Purpose: Emotional Support

### Alternative Treatment/PWA Info Group

Membership: People who are HIV-positive, have ARC or AIDS

Contact: Sandy Davis, (916) 486-2566

Fee: None

Time: Second Saturday, 2 - 3 p.m.

Place: Sutter General, 2801 L St., Conference room B & C.

Purpose: Provide latest information on medical and alternative treatment, group led by people with HIV. Call for upcoming workshop.

### PWA Information and Support Group

Membership: People who are HIV-positive, have ARC or AIDS, male and female, straight and gay.

Fee: None

Time: 2nd and 4th Saturdays, 1 - 3 p.m.

Place: Sutter General, 2801 L St., Conference room B & C.

Purpose: PWA treatment information exchange and support, group led by people with HIV.

### The Positive Group

Membership: HIV + substance abusers and their significant others.

Contact: Brian or Joel, Aquarian Effort, (916) 444-6294.

Fee: None

Time: Thursdays, 1:30 - 3:30 p.m.

Place: 1820 J Street

Purpose: Education and emotional support.

### Brother to Brother

Membership: Gay African-American HIV+ mens Support Group. Dealing with HIV, ARC, or AIDS? Tired of not being counted?

Contact: Joe Hawkins, Project Survival, (916) 454-0516.

Fee: None

Time: Mondays, 7 pm

Place: Call for location

Purpose: Emotional and social support. Strictly confidential.

### Grupo Para Latinos

Infectados y afectados con La virus HIV, Latinos de Habla Hispana o Bilingues - Facilitado por Patricia Osuna LCSW.

Contacto (916) 448-2437.

Fee: None

Tiempo alas 6 p.m.

Lugan, SAF, 1900 K St., Ste 200.

### Woman to Woman

Membership: Women of color who are HIV +, ARC or AIDS. Child care and transportation available.

Contact: Betty Baker, Project Survival, (916) 454-0516

Fee: None

Time: Mondays, 5-7pm

Place: 3501 Broadway

Purpose: Emotional and social support.

### Women's Support Group

Membership: HIV + women.

Contact: Donna Robertson, Sacramento AIDS Foundation, (916) 448-2437.

Fee: None

Time: Call for current hours.

Place: Sacramento AIDS Foundation, 1900 K Street, 2nd floor.

Purpose: Education and emotional support.

### Let's Talk Peer Group (Queers with Fears)

Membership: Gay/Bisexual men only

Time: 2nd, 4th and 5th Wednesdays, 7 - 8:30 p.m.

Fee: None

Place: CARES Clinic, 2710 Capitol Avenue, (916) 443-3299

### Women's Support Group

Purpose: One on one counseling for HIV + women

Contact: Judi Marcelle, Mercy General Hospital Social Services, (916) 453-4589.

Fee: Free

Place: 4001 J Street

## Support Services

### Sacramento AIDS Foundation

Provides AIDS Education, Client Service, Community Outreach and maintains a Volunteer Speakers Bureau. Hand to Hand Emotional and Practical Support volunteers available to clients diagnosed ARC/AIDS. 1900 K St., Ste 200, Monday thru Friday, 9 a.m. to 5 p.m., (916) 448-2437.

### Del Oro Regional Resource Center

Membership: Brain impaired adults

Contact: Connie Garver

Information and referral contractual service for legal and financial advising, counseling, respite care, and referral to support groups.

3625 Mission Avenue, Suite 300, Carmichael 95608, (916) 971-0893.

### CARES Clinic

Provide counseling, early intervention/medical attention to HIV+ individuals. 2710 Capitol Ave, Monday thru Friday, 9 a.m. to 5 p.m., (916) 443-3299. Fee for service.

### Lambda Community Center

Information and resources to help the individual with HIV. 1931 L Street, Monday thru Friday, 10 a.m. to 6 p.m. (916) 442-0185, Info line: (916) 447-5755.

### Being Alive "Living Room"

Drop-in social time for people living with HIV, at the Lambda Community Center every Thursday from 2 to 5 p.m. 1931 L St. For more info call (916) 442-0185.

### Sacramento Aid to AIDS

Joe Garrett, P.O. Box 255773, Sacramento, CA. 95865, (916) 929-3417.

### W.C.I.C. (Women's Civic Improvement Club) - Project Survival

Minority issues and AIDS.

3501 Broadway, 95817, (916) 454-0516.

Contact: Nadine L. Roberts or Joe Hawkins

### The Effort

IVDU treatment program, AIDS education, counseling and confidential testing. 1820 J Street, (916) 444-6294.

### Hospice Care of Sacramento, Inc.

Providing services to persons coping with a terminal illness and their families. 2007 O Street, Ste 100, (916) 443-0398.

Fee: None

### Planned Parenthood of Sacramento Valley

AIDS Education to youth detention, homeless shelters and classrooms. 1507 21st St., Ste 301-A, (916) 446-0930.

Fee: None

### Alcoholic Anonymous

2425 Alhambra Blvd., Sacramento (916) 454-1100

### Narcotic Anonymous

P.O. Box 162416, Sacramento, CA 95816

Fee: None

(916) 486-0465.

### Placer County AIDS Foundation

12183 Locksley Lane, Auburn, CA 95603

Support services for those dealing with HIV in Placer County and surrounding areas.

Call (916) 889-AIDS (889-2437)

## Legal

### Sacramento AIDS Legal Referral Panel

Contact: June Black or Ellen Juarez, (916) 444-6760.

Fee: Reasonable or no fees for AIDS-related matters.

Place: 515 12th Street.

(Must state that you were referred by the Sacramento AIDS Foundation)

## Medical Clinics

### AIDS Related Disorders Clinic (ARDC)

University of California, Davis, Medical Center, Primary Care Building. Provides medical care to people with HIV disease.

2315 Stockton Blvd., Sacramento.

(916) 734-3282 message.

### AIDS Research Office

UCDMC, (916) 734-8282.

### CARES

Provide medical evaluation, personal counseling, health education and referrals for HIV positive people.

Fee for service

2710 Capitol Avenue, Sacramento. (916) 443-3299.

### HIV Clinic

Offers medical care for individuals who need a general work-up related to HIV infection.

Fee: None

1500 C Street, Sacramento. (916) 440-5302.

### County AZT Program

No AZT free.

2921 Stockton Blvd., Sacramento. (916) 732-3770.

## HIV Antibody Testing

### Capitol Health Center

1500 C Street.

Call for information and appointments for free, anonymous test on Wednesday/Thursday, 8 a.m. - 4:30 p.m. (916) 440-7720.

### The Effort

1820 J Street.

Call for information and appointment for free, anonymous test on Tuesday and Thursday evenings. (916) 446-6467, call after 3 p.m.

### California State University, Sacramento, Health Center

6000 J Street. Call for information and free, anonymous test for students, faculty and staff. (916) 278-6461.

### Chemical Dependency Center for Women

1507 21st Street. HIV testing for Intravenous drugs users and their partners. Confidential testing Thursdays, 3:30 p.m. to 5 p.m. (916) 448-2951.

### Hispanic AIDS Community Educational Resources

7000 Franklin Blvd., Ste 210. HIV antibody testing with bilingual counselors available Tuesday evenings from 5 - 7 p.m. Call (916) 392-7815 or (916) 734-8282.

## Spiritual Groups

### MCC People Together

Membership: People who are HIV +, ARC or AIDS, or other catastrophic illnesses and those who love and support.

Contact: Sandy or PJ, (916) 454-4762.

Fee: None

Time: Tuesdays, 7:30 to 9 p.m.

Place: RCMCC Activity Center, 2741 34th Street

Purpose: Social and spiritual support group sponsored by the River City

Metropolitan Community Church.  
Everyone Welcome.

#### **SUFI Healing Arts (MTO)**

Membership: People who are HIV +, ARC or AIDS.

Contact: Linda O'Riordan, R.N., (916) 487-0323.

Fee: Donation requested.

Time/Place: Call for current time and location.

Purpose: SUFI healing, concentration and meditation classes.

#### **Suicide Prevention**

Volunteers available 24 hours to help individuals through times of crisis. TTD capabilities for the hearing impaired. Emergency: (916) 368-3111, office: (916) 368-3118.

#### **Transformational Energetics**

Workshops on transformation and healing primarily focused on deep healing issues for people with HIV and other life-threatening illnesses

Contact: Michael Dulling, MD (916) 422-1234

Fee: Negotiable

### **Support Group for Significant Others**

#### **Support Group for Partners, Family and Friends**

Membership: Partners, family and friends of someone who has HIV/AIDS, and those grieving over the death of a loved one.

Contact: Sharon Hartley, L.C.S.W., and Charla Wistos, (916) 454-1655.

Fee: None

Time/Place: Call.

Purpose: Emotional support.

#### **HIV-AIDS Family Support Group**

Membership: Parents and adult siblings of people who have died of AIDS.

Contact, Todd VanLandingham, Lutheran Church of Our Redeemer, (916) 483-5691 or (916) 456-9642.

Fee: None

Time: 7 - 8:30 p.m.

Place: Lutheran Church of Our Redeemer, 4641 Marconi Ave

Purpose: Emotional Support with a spiritual emphasis.

#### **Hemophiliac Support Groups**

Male Support Group

Membership: Hemophiliac and blood transfusion men with HIV.

Contact: Vicki Burdeen, Bi-Valley Medical Clinic, (916) 442-4985.

Fee: None

Time: Every Tuesday, 9 a.m.

Place: 2100 Capitol Ave.

Purpose: Education and emotional support.

#### **Parents Support Group**

Membership: Parents of adults and children with hemophilia.

Fee: None

Time: 3rd Thursday, 7 - 8:30 p.m.

Place: 2100 Capitol Ave.

Purpose: Education and emotional

support.

#### **For Mothers Only**

Membership: Mother's Peer Support Group

Contact: Peggy Zarembo, 447-5075

Fee: None, Time: Tues. 1:30 pm at SAF

Purpose: Support for mothers of people with HIV, ARC, and AIDS and mothers who have lost sons and daughters to AIDS.

### **Political**

#### **Lobby for Individual Freedom & Equality (LIFE)**

Statewide AIDS lobbying group representing 70 gay, lesbian and AIDS organizations.

926 J Street, suite 1020, (916) 444-0424.

#### **Lambda Letters Project**

Organizes letter writing campaigns expressing community opinions on women's issue, gay & lesbian rights and AIDS issues. The group also offers letter writing assistance to people who would like to express their viewpoints. (916) 965-6851.

#### **AIDS Action League**

Offers housing assistance to people with AIDS. Organizes projects which directly benefit people with AIDS and provides educational information.

Fee: Negotiable

2612 J Street, Ste. 6, Sacramento, (916) 448-4027.

### **Food**

#### **A Touch of Sabbath**

A monthly delivery of homemade chicken soup and challah (bread) the last Friday of each month for people with AIDS or ARC. For more information call (916) 921-1313 or (916) 482-1432. Free food closets...

### **Products**

#### **Sunergy - Herb Food Concentrates**

Sunrider nutritional products and philosophy formulated after the ancient Chinese tradition of nourishing the body with whole foods and the proper combination of herb foods. Local distributor: Gina Milbourn, (916) 991-0860.

#### **Reliable Medical Resources**

Quality health care products ranging from personal aids/support equipment, incontinency protections and skin care products. Available at no cost to individuals with Medi-Cal/Medi-Care coverage. Lowest cost to insurance plans and private pay. (916) 383-6868.

### **Information**

#### **Project Inform**

Non-profit information resource group and hotline for alternative and experimental treatment updates including Compound Q, alpha interferon, AZT, aloe vera juice, ribavirin, DNCB, etc. (800) 822-7422 or (415) 928-0293.

#### **AIDS Treatment News**

Bi-weekly publication that covers up-to-date issues on alternative and holistic therapies. Subscription charge with a reduced rate for people with HIV. Write John James, P.O. Box 411256, San Francisco, CA. 94141.

#### **National AIDS Information Clearing House**

Local and national computerized resource listings and informational publications, many available free of charge to people with HIV such as the AMFAR (American Foundation for AIDS Research) Directory of Experimental Treatments. Call (800) 458-5231 or (212) 719-0033.

#### **BETA (Bulletin of Experimental Treatments for AIDS)**

Publication of the San Francisco AIDS Foundation. Educational resource for people reviewing experimental treatments for HIV. Free to San Francisco residents, subscription charge for others. Call (800) FOR-AIDS for sample copy and information.

#### **NIH (National Institute of Health)**

Drug Trials Information

Toll-free phone line with information on federally funded clinical trials researching AIDS treatments with information provided by APA MONITOR (American Psychological Association). 1 (800) TRIALS-A or 1 (800) 874-2572

#### **Northern California AIDS Hotline**

1(800) 367-2437.

#### **AIDS Drug Hotline**

1(800)334-7422.

#### **U.C. Davis Medical Library (MED-LINE)**

(916) 453-3529.

#### **Persons with AIDS (PWA) Hotline**

1(800)367-2437 or (415) 861-7309.

#### **Natl Association of People With AIDS**

2025 Eye Street, NW., Ste. 415 Washington, D.C., 20006 (202) 429-2856

#### **Mothers of AIDS Patients**

P.O. Box 89049, San Diego, CA. 92138, (619) 426-1317

#### **Teen AIDS Hotline**

1(800) 234-TEEN  
National Library of Medicine  
(for subject searches, AIDS LINE)  
(301) 496-6095.

#### **The NAMES Project**

Educating the world by remembering those who have died of AIDS by creating memorial quilt panels with love.

2362 Market Street, S.F., (415) 863-5511.

### **Religious Services**

#### **River City Metropolitan Community Church**

3418 Broadway, corner 3rd Avenue, (916) 454-4762.

Sunday Worship services: 9 a.m., 11 a.m. and 6 p.m., Sunday School during 11 a.m. worship for children 2 to 12. TV Ministry on Channel 47 Monday at 10 p.m., Tuesday at 5 p.m. and Wednesday Noon.

### **Newspapers (Available at Lambda Community Center)**

#### **the latest ISSUE**

"Sacramento's news magazine for the gay community and its friends," P.O. Box 189306, Sacramento, CA. 95816 (916) 737-1088

#### **MGW**

First and oldest newspaper for the gay community, 1725 L St., Sacramento CA 95814, (916) 441-NEWS

#### **Patlar**

"Voice of Gay America," P.O. Box 22402, Sacramento (916) 452-0769

#### **BLK**

Blk Publishing Company, P.O. Box 83912

Los Angeles, CA. 90038-0912

#### **The Sentinel**

"California's Statewide Gay Newsweekly. Call (415) 861-8431 for subscription information.

#### **Bay Area Reporter (BAR)**

Excellent information and news source. 395 Ninth St., S.F., CA. 94103. Available at Tower Books or by subscription. Call (415) 861-5019 for information.

### **Workshops**

#### **Buddy Connection**

Unique fun-filled opportunity to explore exciting ways to be sexual, safe and satisfied.

Fee: None

Call SAF for dates and times (916) 448-2437.

# Politics and AIDS

by Stan Hadden

## 102nd Congress Convenes

Former State Senator John Doolittle was among 42 freshman members taking an oath of office and being seated in Congress in January. Doolittle now represents Northern California's 14th Congressional district. As a new member, his voice won't carry as much weight among the 435 members of Congress as it did in the 40 member State Senate. However, Doolittle has already aligned himself with conservative Southern California Republicans, stating that Representatives Dannemeyer and Dornan are friends, and that he expects he would align with them on major issues. Dannemeyer & Dornan are known for outspoken opposition to gay rights. California's Republican members of Congress have chosen Doolittle to head their redistricting committee and serve as liaison to state lawmakers on redistricting. This spring and summer the California Legislature will determine new boundaries for Congressional, Senate and Assembly districts and the location of the seven new Congressional seats California gains because of population growth.

During the 102nd Congress, federal AIDS research and prevention programs must be reauthorized. Final agreement was not reached last year in a number of areas, so the new Congress must give priority to early medical intervention for drug users with HIV and removal of the current prohibition against bleach distribution with federal funds. Low salary levels have left numerous AIDS research positions vacant at the National Institutes of Health, and Congressional Democrats will seek higher compensation to encourage the best researchers to join NIH and the AIDS research effort.

## Elsewhere in Washington

Last November President Bush signed the federal budget bill which is more than 1,000 pages long, weighs more than 24 pounds and stands 10 inches high. The federal budget is \$1.45 trillion. Interest payments on the federal debt will cost \$206 billion. During 1990, Congress increased AIDS spending from \$1.53 billion to \$1.9 billion, a 20% increase. Bush has proposed adding only \$65 million for AIDS programs in his new federal budget proposal. Under Presidents Carter and

Reagan, the federal government cut grants for housing, education, transportation & public works — shifting a heavy financial burden to cities and states.

The budget compromise last fall by Congress and the President provides some added money for domestic programs this year, but freezes domestic spending for the next two years. Significant federal increases for AIDS spending are unlikely.

## California's New Governor

Numerous lavish events marking Pete Wilson's inauguration were a marked contrast from the aloof image of former Governor Deukmejian. Wilson's organizers suggested these "people oriented events" were done to accentuate the positive and express an attitude of optimism. Many of the early January events included ample time for handshaking and crowd-mingling. Inaugural committee director Martin R. Wilson suggested Pete Wilson is very people-oriented. He likes to talk to people — he wants to shake their hands. This friendly attitude apparently did not extend to AIDS or lesbian and gay activists who were arrested and

forced out during inauguration ceremonies. Many of the Republican faithful attending these events, including members of the gay Log Cabin Republican club, expressed outrage at the Act Up and Queer Nation actions.

Early indications are that Governor Wilson will not be unduly influenced by the conservative right. Unveiling his \$55.7 billion spending plan for California, Wilson proposed a \$10 million increase for family planning programs. The budget calls for some program cuts, which many Democrats don't like, and some tax increases, which are offensive to many Republicans. Wilson suggests raising taxes to pay for certain health services and shifting certain health responsibilities from the state to local government.

For AIDS programs, Wilson proposes \$125.5 million in state funding. This is essentially a no-increase budget for AIDS prevention and patient care programs. Current funding for clinical trials of an AIDS vaccine is eliminated from the budget. Because the state is facing a deficit of \$6 to \$8 billion, prospects for increased AIDS funding are low.

## Researchers Recommend TMP-SMX Over Aerosolized Pentamidine

Extolling the cost-effectiveness and superior efficacy of trimethoprim-sulfamethoxazole (TMP-SMX), researchers are challenging the routine use of aerosolized pentamidine as a prophylaxis for *Pneumocystis carinii* pneumonia.

Several studies presented at the 30th Interscience Conference on Antimicrobial Agents and Chemotherapy, held recently in Atlanta, suggested that TMP-SMX is well tolerated by a majority of patients and prevents primary and secondary bouts of PCP. Two of those studies compared aro-

solized pentamidine with TMP-SMX and found the latter to be more effective.

The cost per month of TMP-SMX, using a dosage of one double-strength tablet twice a day, is about \$8.50. The monthly cost of aerosolized pentamidine is \$187. (That includes the cost of the drug and the nebulizer, and the respiratory therapist's salary).

The TMP-SMX regimen would cost \$277 per disease-free month per patient and \$22,229 per death averted, according to the study. Aerosolized pentamidine, on the other hand, would

cost an estimated \$481 per disease-free month and \$41,788 per death averted.

Both regimens are recommended for prophylactic therapy by the Centers for Disease Control in Atlanta. Although neither drug is recommended over the other, aerosolized pentamidine has been widely used because of its low toxicity. TMP-SMX causes toxic reactions, most commonly a rash, in some patients.

In 1991 alone, if all eligible patients without known allergies to TMP-SMX were given the drug, 2,726 deaths from PCP

would be prevented, thereby saving \$362 million in hospital costs, Nettleman said. In comparison, if aerosolized pentamidine were the chosen regimen, 232 additional deaths would occur and an additional \$56 million would be spent, she said.

In addition to being more cost-effective than aerosolized pentamidine, a systematic prophylactic regimen, such as TMP-SMX, may prevent extrapulmonary PCP, which has been reported in some patients who have received it.

—AIDS Alert

# Are We Facing A New AIDS Crisis?

## AIDS In Women Reveals Health Care Deficiencies

Women make up a steadily increasing proportion of all AIDS cases—between 11 and 12 percent of recent diagnoses in the United States. Yet most scientific knowledge about infection with the human immunodeficiency virus-type 1 (HIV-1) comes from studies of the disease in homosexual men. A few studies indicate, not unexpectedly, that some manifestations of HIV-1 infection are different in women from those in men. But such differences remain poorly understood, and AIDS patient advocates charge that the health-care system fails to address women's needs.

CDC expects AIDS will be among the top five causes of death in women of childbearing age (15-44 years old) in the United States this year. Moreover, poor minority women, whose access to medical services is often limited, account for a disproportionate number of female AIDS cases. Blacks and Hispanics make up 73 percent of the 15,133 cases of AIDS recorded in women through November 1990.

Women tend to die sooner after an AIDS diagnosis than men, but the reasons why are not clear. Ruth Berkelman, chief of AIDS surveillance at CDC, says

this was especially true early in the epidemic and could indicate that early recognition of the disease has been less likely for women than men. This may reflect inadequate health care for poor, minority women in general, or the high rate of intravenous drug use among women with AIDS—51 percent compared with 18 percent of the men with AIDS, according to CDC figures.

The definition of AIDS does not include among AIDS indicator diseases certain conditions that are common in HIV-1 infected women, such as pelvic inflammatory disease (PID), vaginal candidiasis (a yeast infection), and precancerous cervical disease. As a result, activists say clinicians may fail to recognize symptoms of HIV-1 infection in women. They also contend that HIV-1-positive women who do not fit the AIDS case definition are denied Social Security disability benefits.

About 51 percent of women with AIDS are intravenous drug users, and another 21 percent are sexual partners of intravenous drug users. The drug-using subculture is not particularly well connected to the research subculture.

—*Journal of NIH Research*

## Frightening Trend Among Teen Girls

By Sonya Cox

A sharp increase since 1985 finds nearly 52 % of female teens between 15 and 19 have had premarital sex. The numbers escalate with age: 70 % of 18 year olds and 75 % of 19 year olds reported sexual experiences.

More than 2.5 million girls are treated for sexually transmitted diseases each year, including a high rate of pelvic disease which can lead to sterility and

aborted pregnancies. It's not yet known how many have thus far been exposed to HIV and will eventually develop AIDS and have babies with AIDS.

The blame, says the Centers for Disease Control, lies with schools that haven't implemented programs to emphasize that if students aren't going to abstain from sex, they must practice behaviors that reduce their risk of infection.

## AIDS Risk for Younger Gay Men

Signs that the AIDS virus is spreading among younger homosexuals are prompting fears that another generation of gay men will be wracked by tragedy.

The high toll of AIDS among gay men so far has largely resulted from the rampant spread of the virus during the late 1970s and early 1980s, a time when few people were even aware of a disease that was only recognized by doctors in 1981. In some cities like New York and San Francisco, close to half the gay men became infected in that period.

Since then, encouraged by a barrage of information and the example of deathly ill friends, gay men have largely changed

their behavior. Huge numbers adopted "safer sex" practices, like using condoms or avoiding anal intercourse, and the rate of new AIDS infections slowed drastically, studies have found.

The hope was that in the new climate of AIDS awareness succeeding generations of gay men could avoid disaster. Gay men accounted for more than 60 % of the 152,000 cases of AIDS reported through September.

But sketchy evidence suggests that many homosexual teenagers and young adults are still engaging in unprotected intercourse, and that many are becoming infected with the AIDS virus, leading to calls for much more aggressive prevention campaigns.

—*The New York Times*

## AIDS Impacting Black Americans

In testimony before the National Commission on AIDS, in a meeting in Baltimore, Maryland, black doctors said that a historic mistrust of medical authorities is keeping HIV-infected blacks away from treatment.

"AIDS is one of the many scourges affecting African-American communities, intertwined with poor education, drug dependence, inadequate health care and general malaise," said Dr. Mark Smith, associate director of AIDS services at Johns Hopkins Hospital. "It affects a population al-

ready alienated from the system."

"Two years ago, I began to hear stories of parents who told their children not to be out on the streets after dark—doctors would snatch them off the street and experiment with them. I heard the bogeyman story a lot, and I suspect it's being told by people in neighborhoods around other research institutions," he said.

Black Americans account for about 28% of the U.S. reported AIDS cases.

—*CDC AIDS Weekly*

## HIV Infection On Campus

Assays of over 16,000 blood samples collected in health centers at 19 US universities revealed an HIV Seroprevalance rate on campus of 0.2 percent (one in 500 students), within the range found in other national surveys. While no HIV infection was found at over half of the schools, one school had a rate approaching 1 in 100. Seroprevalance increased with age, reaching 1 percent in students over 40, and was 25 times higher in men than in women. Because many students still have misconceptions about the modes of HIV transmission, and because some high-risk behaviors (such as sex with many partners) are common on campus, HIV may spread further in this population. Education is essential to check this spread.

—*AIDS Clinical Care*

## AIDS Dementia Complex

Provided by Connie Garver, B.S.W., Family Resource Coordinator, Del Oro Regional Resource Center

AIDS Dementia Complex (ADC) is a progressive neurological disorder that can affect persons who are infected with the Human Immunodeficiency Virus (HIV). It is thought to be a subcortical dementia and is characterized by cognitive, motor and behavioral impairments.

### Facts

Although the precise incidence and prevalence of AIDS Dementia Complex is uncertain, it has been estimated that approximately two-thirds of the individuals with AIDS will develop dementia or related neurological disorders. The leading hypothesis regarding ADC is that it is caused by direct infection of the brain by the Human Immunodeficiency Virus (HIV), the cause of AIDS. In 1987 the Centers for Disease Control included AIDS Dementia Complex as a primary diagnostic condition that warrants a diagnosis of AIDS.

### Symptoms

The early manifestations of AIDS Dementia Complex may include:

**Cognitive:** Memory loss (difficulty recalling appointment times, telephone numbers, or names), impaired concentration (trouble keeping track of conversations or completing thoughts), and mental slowing (not as "quick" as usual, slower at responding to questions).

**Motor:** Difficulty with gait, balance, coordination, leg weakness, clumsiness and deteriorating handwriting.

**Behavioral:** Impaired judgment (impulsive behavior, poor decision making), personality changes (apathy, social withdrawal, irritability), mood changes (extreme highs and lows, anxiety, emotional outbursts), and occasionally psy-

## Peptide T: New Access Obstacles

By John S. James

For several months there have been increasing reports of difficulty in obtaining Peptide T, an experimental treatment which is generally agreed to be safe and is in clinical trials. Recently the situation came to a head when two buyers' groups had their supplies cut off due to Federal action against two different suppliers; in one of these cases, Ron Woodruff of the Dallas Buyers' Club sued the FDA, and lost in Federal court in San Francisco.

Peptide T has been a hidden but appalling scandal for years. *AIDS Treatment News* first covered this drug four years ago, on January 16, 1987. At that time we reported that the drug had been given to four terminally ill patients in Sweden, and their condition had improved. We concluded that January 1987 article with an unfortunately prophetic paragraph:

"The public, through its AIDS, medical, and other public-service organizations, must continue to watch the development of Peptide T, as well as other treatment research. In the past, too many promising AIDS treatment leads have been strangled in red tape or left on the shelf to collect dust instead of being tested promptly. Only continuing public vigilance can make sure it doesn't happen again."

Later, we heard a credible (but not confirmed) report that the Swedish research had been stopped by U.S. pressure.

It would take a book to trace the convoluted history of Peptide T and investigate the many allegations of wrongdoing in its history. What happened to this drug is a grotesque microcosm of problems with drug development in this country. We do recommend such a study for a serious researcher; many hundreds, if not thousands, of pages of documentation are available.

Does the drug work? Our un-

derstanding is that it was originally intended to be an antiviral, and did show such activity in laboratory tests; the mechanism of action was believed to be similar to that of soluble CD4; i.e., preventing the virus from binding to and entering uninfected cells. But human tests which looked for antiviral activity were disappointing, and as a result some researchers lost interest. Clinical trials have, however repeatedly found neurological or other symptom improvements.

Personal reports we have received do suggest that the drug is helping—even if the mechanism is not known. For example, one of the people whose supply was recently cut off told us that he had been trying AIDS treatments for years, and had been through the "placebo effect" many times, enough to tell that his improvement with Peptide T was not just a psychological effect from trying a new treatment.

We do not know how difficult it will be to get Peptide T in the future. Unfortunately, the drug is rather expensive. It is usually administered by injection; it can also be prepared for nasal use, although that route is less efficient.

One big unanswered question is why would the FDA move against Peptide T now? Everyone agrees the drug is safe. Furthermore, as far as we know, it is not being and has not been promoted. Instead, a few people learned that the drug was especially helpful for them—sometimes by volunteering for FDA-approved trials and then having their drug cut off when the trial ended—and quietly found ways to obtain a supply, either from U.S. or international sources. This system has continued for many months, if not for years, and as far as we know there have been no problems, no complaints. When there are many real problems to worry about, why would the FDA move now on a non-problem, when doing so will not do anyone any good, and may cause some people serious harm?

## Anti-anemia Drug Backed in AIDS War

The Food and Drug Administration approved a drug that fights the anemia that forces some people with AIDS or AIDS-related conditions to abandon life-prolonging AZT therapy.

The drug, Epoetin alfa, a genetically engineered form of the kidney protein erythropoietin, stimulates the production of red blood cells. Anemia is a shortage of red cells.

About 60 percent to 80 percent of the 25,000 people taking AZT become anemic, said officials at Ortho Pharmaceuticals Corp., one of two companies that will market the drug.

Many of these people become so anemic that they need regular blood transfusions or are forced to give up the AZT therapy.

The FDA approved Epoetin alfa for use in patients with chronic renal failure in June 1989.

At that time, while the drug's effects with acquired immune deficiency syndrome and AIDS-related conditions were studied, the agency also expanded access to Epoetin alfa for patients on AZT.

The new treatment has few adverse reactions. Most frequently reported are fever, headaches and fatigue, the FDA said.

Amgen Inc. of Thousand Oaks, California, will market the drug under the trade name Epogen, while Ortho will market it under the name Procrit.

—The Sacramento Bee

*Dementia...continued from Page 12*

chotic behavior (hallucinations, suspiciousness, grandiose thoughts).

As the disease progresses, people with AIDS dementia may become increasingly confused, weak and lethargic, and develop severe memory loss. Each person experiences these changes at different rates and not everyone develops all of these manifestations. The onset and course of dementia is also variable, with some persons sustaining stable mild dysfunction for long periods of time, and others exhibiting steady worsening within a few months.

### Diagnosis

The symptoms of AIDS Dementia Complex can resemble those of other medical and emotional problems. Some of these problems arise from treatable opportunistic infections such as toxoplasmosis or cryptococcal meningitis or from other treatable disorders such as depression, anxiety, nutritional deficiencies, recreational drug use and the side effects of medication.

In order to diagnose ADC and treat any reversible causes of dementia, a thorough medical and neuropsychiatric evaluation is recommended for anyone suspected of having neurological complications related to AIDS. The evaluation usually includes a physical and neurological exam, blood tests, neurological procedures (e.g., lumbar puncture, EEG, CT scan) and neuropsychological testing.

### Treatment

Although there is currently no cure for AIDS Dementia Complex, recent studies have shown that Azidothymidine (AZT) may

help to improve attention, fine-motor coordination and memory. Additional antiviral therapies are being explored.

In addition, a "treatment plan" usually consists of making the situation more manageable for the caregiver and the person with ADC. For instance, various strategies can be utilized to help individuals compensate for and minimize the impact of lost abilities. Providing memory aids (calendars, clocks, lists), structuring the environment to maximize safety and familiarity (keeping home uncluttered, placing photographs around the house), and using verbal and non-verbal cues (saying the person's name, maintaining eye contact) are all ways to minimize over-stimulation, keep the person oriented and structure the environment.

Supportive and personal care services provided at home or in other residential settings are also available to aid families and friends caring for someone with AIDS Dementia Complex. Respite care, day programs, transportation, housekeeping and related community resources can help provide for basic physical, social and emotional needs and assist in alleviating the burden of care.

Caregivers can often benefit from individual counseling, group therapy and/or support groups. Sharing information and discussing feelings of frustration, fear, loneliness, guilt and depression with others can help decrease feelings of isolation and validate the caregiving experience. Legal assistance also may be necessary to plan for the financing of care, arrange surrogate decision-making and to protect the rights of partner.

*"Mr. MIB"...continued from Page 1*

illnesses such as cancer or hemophilia.

The bill was loosely written in order to allow the five member board, known as "MR. MIB" (Major Risk Medical Insurance Board), which was set up to implement the program, broad powers to solve problems.

Since the board's first meeting Stan Long, 36, a Los Angeles design consultant, who is HIV positive and a member of ACT UP, has attended every session. "The board met once in Los Angeles," Long said, "but the rest of the time they've met in Sacramento at least once a month and since August the meeting were upped to every two weeks."

"This is the only health insurance I can buy in the State of California," Long said. "I attended board meetings because I wanted to have a say in how the program was set up — and I've been able to do that. This board, which consists of four men and one woman, three of whom were appointed by Governor George Deukmejian, have worked within the context of the law. They have been sensitive to the issues and have had to make hard decisions on hard issues. They've done a really good job with what they've had to work with," Long said. Long was referring to the \$30 million in state tobacco funds the board has to allocate which limits the number of people who can be covered by the insurance to 10,000.

Long was the person instrumental in making sure that the words "sexual orientation" are included in the board's non-discrimination clause. He also spent at least three meetings urging the board to include the words "health status" in the non-

discrimination statement. "It's absolutely essential to have health status included in these clauses everywhere — there is an enormous amount of discrimination against people with all sorts of diseases and although it's implied in the mission of the bill, it was necessary to state it — because it could be overlooked in the Office of Administrative Law if the clause was not spelled out."

The California Faculty Association, the Lobby for Individual Freedom and Equality (LIFE), several unions and the City of West Hollywood followed the board's actions and also stressed the need to include health status in the non-discrimination clause.

Currently, Long is working with the board on the concept of domestic partners coverages. "This was an educational process," he said. "You have to understand that some of these people had never heard the words or thought of the concept of non-traditional families. Now the board understands the issue and we can make the move toward domestic partners coverage. They can see how causing people in the same household to hold two policies with their separate deductibles and out of pocket caps would be unfair."

Under the current ruling each insured person is required to pay the first \$500 in medical bills per year after which the insurance coverage activates. The insured person then pays 20 percent of all medical bills, up to a ceiling of \$2000 in one year, after which 100 percent coverage goes into effect. However, for families, the same \$500 deductible and a \$3000 cap on expenditures is in effect and is cumulative to the family unit rather than to the individual members. So the \$500 deductible is paid only once regardless of how many family members get sick and the same applies to the \$3000 cap. Benefits are limited to \$50,000 a year with a lifetime cap of \$500,000.

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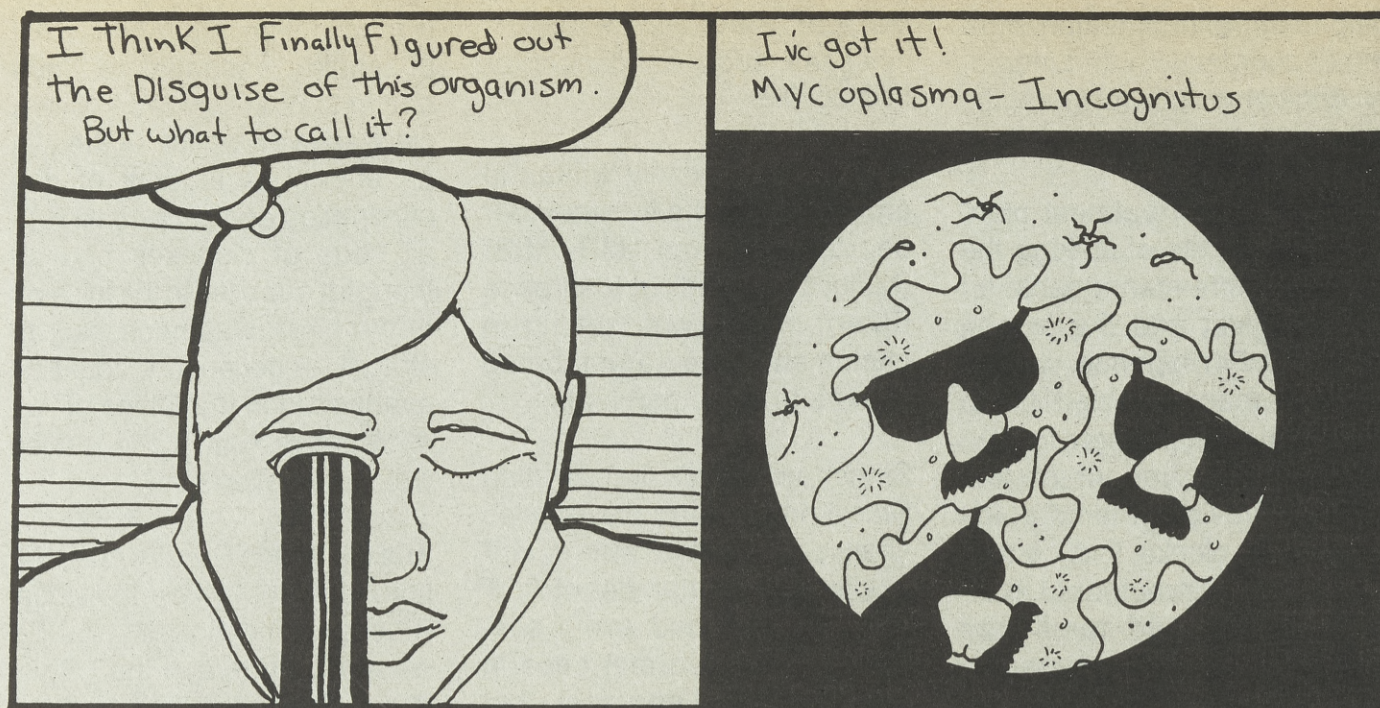
*Update...continued from Page 1*

Owen stated at the time the petition was submitted.

In a similar move, 24 members of Congress signed a letter to the FDA last November urging early approval of the drugs for constituents whose treatment

options were limited and who could benefit from access to either drug. The politicians wrote, "...if we allow Phase II drug trials to continue while remaining restricted to the existing criteria of expanded access, then we are condemning to

death all those who can benefit from the early review and early release of these two promising drugs. If we do this, if we follow need with inaction, then we are wrong. And our inaction will cost us dearly. It will cost us lives."



Second ...continued from Page 1  
up with medical care. This is not to say the information is inaccurate, but more likely incomplete and outdated.

For example, the author of the article, Elinor Burkett, a reporter for *The Miami Herald*, states, "Diseases presumed to signal AIDS are cropping up in individuals without any trace of HIV. Why? No one knows."

Dr. Siegel points out that yes, some cancers such as Kaposi's sarcoma and infections such as *pneumocystis carinii* pneumonia (PCP) occur in people not infected with HIV. PCP is carried in almost everyone's lungs from childhood. Normal immune systems do not allow this infection to become harmful. In the immune compromised individual, however, it is deadly. People being treated with radiation or chemotherapy for cancer may develop PCP also because these treatments often result in immune compromise. Although these patients develop PCP, they do **not** have AIDS. Most of

the opportunistic infections are reactivations of infections people with HIV had previously, and have the "opportunity" to recur because the immune system has broken down and can no longer fight back.

Another example from the article: "The vast majority of those known to be HIV-infected remain healthy for years—and there is no proof they will not live a normal lifespan. Why? No one knows." Again, this is a misleading statement according to Dr. Siegel who says, "First, we've only known about this disease for a decade, thus we do not know just how long a person may live. We do know that some people are genetically better able to fight off viruses and infections than others. The author refers to the cohort of gay men in San Francisco who were involved in the hepatitis study. Although she reports the percentage of patients who went on to develop AIDS, she neglected to mention that most of those remaining have gone on to show signs of progressive

disease. There certainly will be those people infected with the virus who may not exhibit any symptoms or go on to what we know as AIDS, but this should not result in those infected delaying medical intervention for their own protection as well as that of others with whom they come in contact." He states that others will delay onset of HIV/AIDS because of different co-factors, or those triggering mechanisms which start up the viral replication and progression of disease. Those who participate in high-risk activities on a regular basis most likely will progress at a more rapid rate. Therefore, the statement is not accurate, and deserves a second look before stating no one knows why this happens, because much has been learned about the way the virus operates.

Dr. Siegel agrees with the author that scientists have not learned **all** there is to know about AIDS, but it has only been 10 years since the first case was diagnosed. And, considerable

knowledge has been collected including treatments not only for AIDS, but for cancers and other terminal illnesses. Home health care and Hospice care have taken on new meanings and allow patients to remain at home in comfortable surroundings if not for the duration of their illness, certainly the majority of it.

HIV infection does result in AIDS by destroying the body's T-helper cells. This leaves the body open to many infections which the normal immune system would be able to fight off. Co-factors such as some sexually transmitted diseases (herpes, syphilis, gonorrhea, venereal warts), shigella, and mycoplasma cause HIV to progress more rapidly to AIDS. These and many other co-factors have existed for a long time, but when added to the scenario of HIV they help progression of disease.

In relation to *The Bee* article, Dr. Siegel cautions HIV positive individuals to keep an open mind when reading these types of articles and urges a frank discussion between patient and physician when new theories and/or treatments are introduced. Much can be gained by both parties in an open and honest discussion.

"Take hope that you will live longer and in better health than those who acquired HIV before you," he concludes. "It now appears at least theoretically possible to stop progression of HIV in those people infected today, and, maybe one day we will be able to stabilize the disease and possibly rebuild the immune system."

"Mr. MIB"...continued from Page 13

Long is hopeful that once the board is comfortable with the fact they are able to implement a domestic partners decision the next step will be to find out if they are, indeed, willing to do so.

Coverage began in January. Blue Cross is administering the program for the state and contracts have been signed with Pacific Mutual's PM Group Life

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Insurance Company and Blue Shield of California. Thousands are already on the waiting list. Persons who are in the high risk insurance category should apply immediately for coverage. Contact John Ramey, Executive Director, Major Risk Medical Insurance Board, 744 P Street, Sacramento, CA 95814 or call 916/324-4695 or 1-800-333-0912.

### ddl: Smoking & Drinking

By Sonya Cox

Researchers recently reported they've found evidence that nicotine can induce chronic pancreatic damage in animals, which may explain why large numbers of smokers develop chronic pancreatitis. Scientists have known all along that alcohol is a factor in about 90 percent of pancreatitis cases, but if a drinker also smokes one or

more packs a day, the risk increases nine-fold.

Bear this in mind if you're in the growing group taking ddl, which also can cause problems with the pancreas in some people. You may want to make an extra effort to give up smoking and heavy drinking if you're on ddl, or getting into your second or third year of AZT and may in the future be switching to ddl if you become intolerant to AZT.

Danger...continued from Page 1

HIV either inform their patients or entirely stop performing surgery. Doctors, the AMA says, have an ethical obligation that's almost as old as medicine itself not to do harm to their patients.

The CDC itself estimated recently that between 13 and 128 people in this country have been infected with HIV as a result of medical treatment given by dentists or doctors. Despite the estimate, the CDC admits that the three cases in Florida - all patients of the same dentist - are the only ones it can document, and even then the connection is only considered "possible" in CDC's jargon.

But for the AMA, the ADA and Dr. Lorraine Day, former chief of orthopedic surgery at San Francisco General Hospital, even such remote risks appear to be unacceptable.

Day testified that, "the uninfected must be protected .... I don't have the right to put a patient's life at risk. If surgeons don't want to get tested, it's because they are selfish and they don't want to worry about the rights of someone else."

#### **'You Will Be Abandoned'**

On the other side of the CDC debate in Atlanta, however, was a wide array of other medical, civil rights and AIDS organizations arguing against CDC restrictions against infected medical personnel. Among them were the American College of Surgeons, the American Hospital Association, the American Federation of State, County and Municipal Employees, the American Public Health Association, the Infectious Disease Society of America, the ACLU Foundation, and the American Association of Physicians for Human Rights.

And the arguments here ranged from purely practical concerns over loss of livelihood to philosophical concerns over privacy issues to questions of whether such Draconian measures are justified based on the evidence at all.

Dr. Hacib Aoun, a physician who contracted AIDS from a patient at Johns Hopkins Hospital, speaking of the double standard health-care workers are beginning to experience in the epidemic, told the Sixth International AIDS Conference in San Francisco last year, "We ask you to be in the front lines, but if something happens to you, we will not stand behind you. You will be abandoned and will be deprived of the privilege of practicing medicine."

**"The public perception of this disease is one of it's being very insidious and dirty and somehow much more contagious and basically different from other communicable diseases, which hospitals contend with constantly. The easy way out in the short term is to say everyone has to be tested. But in the long run, that only validates the hysteria surrounding AIDS which was only beginning to calm down somewhat."**

#### **—Dr. Gary Pasternak**

Others pointed out that, although there seems little doubt the three patients in Florida were infected by their dentist, how those infections occurred is still a mystery that might give more guidance on protecting patients that a blanket ban on HIV-positive health-care workers. Was the dentist following basic medical hygiene procedures and if not, why? If the dentist's infection was transmitted through inadequate hygienic techniques, given the long incubation period before HIV can be detected by laboratory tests, how would testing medical workers have helped in that situation.

Others point to the 24 documented and 16 additional reported cases of health-care workers being infected with HIV through contact with patients as clearly a far more serious

concern for medical personnel than doctor-to-patient infection.

Still others say the risk of infecting patients is minimal compared to the many other risks that routinely are taken in hospital settings.

Dr. Norm Schram of the American Association of Physicians for Human Rights offered a pseudo-questionnaire that patients might be better off putting to a prospective surgeon. "How much alcohol do you drink during the week," the mock inquiry asked. "Do you smoke? If so, do you ever crave tobacco during long operations? How often do you operate after less than seven hours of sleep? For female surgeons: Do you have PMS? Does it ever bother you when you operate?"

Schram's questionnaire was silly, of course; it was meant to be. But the message isn't trivial.

The risks of dying during an operation performed by a surgeon who drinks too much or is operating after a 20-hour shift on duty are probably much greater, Schram said, than the risk of contracting HIV infection from a hospital worker.

#### **AIDS Hysteria Redoux**

Some of those testifying during the CDC hearings expressed concern that the three reported cases in Florida have prompted a public overreaction that the AMA and ADA positions have only fueled. They also expressed concern that if the CDC isn't careful about how it responds to the public hysteria over the remote possibility of infection by health-care workers, the public hysteria over mandatory HIV testing of all hospital patients and others could be opened up again - which is exactly what Dr. Day suggested should happen.

Dr. Gary Pasternak of the Valley Medical Center in San Jose summed up the delicate balance between legitimate transmission concerns and further outbreaks of hysteria this way: "The public perception of this

disease is one of it's being very insidious and dirty and somehow much more contagious and basically different from other communicable diseases, which hospitals contend with constantly. The easy way out in the short term is to say everyone has to be tested. But in the long run, that only validates the hysteria surrounding AIDS which was only beginning to calm down somewhat."

It is probably unlikely the CDC is going to adopt the severe and coercive position the AMA and the ADA have taken in recommending that infected health workers inform their patients or stop performing invasive medical procedures.

But if the CDC responds with even moderate concessions to the AMA-ADA position, the whole debate over mandatory testing and job restrictions could well get a vigorous rerun. There are more than enough Dr. Days waiting in the wings for to renew another AIDS panic.

One sublime irony, that only government agencies seem capable of generating, was overlooked amid the heat generated at the CDC debate over possibly restricting medical workers infected with HIV in their jobs, however. The same day the CDC gathering began in Atlanta, the Justice Department in Washington proposed new regulations to enforce the 1990 Americans with Disabilities Act, which bars discrimination against the disabled - including people with HIV infections.

No one noticed that while one government agency was hearing testimony about restricting the kinds of job medical professional can do, another federal department was explaining in detail exactly how such restrictions were going to be prevented by the federal government.

It was, as Dr. Aoun told the CDC, "an awful message to send to the health care worker." He might have added that it was a pretty confusing message to send to the rest of us as well.

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Big hunky top man wanted by attractive, charming accommodating bottom. Me: HIV+, 27, 6" 160 lbs. You: top, hung, reasonably good looking. Allen (415) 252-5831.

New to area, still learning how to be a GWM, 40, 5'7", 175 lbs. Brown/brown, moustache, very good looking, HIV-, good body, honest, sincere, great sense of humor. I like travel, movies, and music, even going to straight places. Looking for above average looking, quality friends with my attributes. Write PO Box 4551, Citrus Heights, CA 95611.

Handsome young 47 GWM, HIV+, 5'11", 180 lbs, brown/blue, masculine. Enjoy movies, travel, home cooking. Seeking responsible masculine GWM 25 - 40 for friendship, good times and possible relationship. Call Wayne, 348-8542.

I have a country twang and I can sang. Can you play the piano? I'm tired of the gay bar. Can you play the guitar? Does your pelvis shake like Elvis? Write to M. CC. 500 N St. #1107, Sacramento, CA 95814

GWM, HIV+, 30 looks 23, 24.

5'9", 145 lbs, brown/brown, healthy. Like to meet young man, blond preferred but others are too. Likes movies, animals, sun, homelife, exercising & love. No druggies, fems, wierdos, gossippers—You get the point. Call 448-1445 or write c/o PSSN.

GWM29 looking for that special someone. I'm 6'2", wt. 210 lbs. with hazel eyes & brown hair. I have short beard and moustache. If your spirit would like to meet my Spirit, please call or write (916) 448-4782 or P.O. Box 161924, Sacramento, CA 95816.

Friendly Bi. I've got a wiener-dude attitude! I'm a white Bi Male, 34 years old, 6'1", 180 lbs. Looking for any kind of Safe Sex Adventures with anyone out there. I'm very friendly, clean, easy going and HIV-. Expect same. For a good time, call Jim at (916) 386-8444.

GWM, 29, brown hair, blue eyes, 5'10", 170 lbs. HIV+, Healthy, seeking a mature GWM 25-50 who is honest, serious about life, building a lasting relationship. I'm not into heavy drinkers, druggies, queens, or hustlers. I like movies, oldies music, reading, outdoor sports, fishing, camping. Does any of this sound interesting? Write to R.P.M. 8665 Florin Rd. #77, Sacramento, CA 95828.

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